

Prime Care Homes Limited

Clitheroe

Inspection report

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Clitheroe
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06 July 2016
13 July 2016

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced inspection of Clitheroe on 5, 6 and 13 July 2016.

Clitheroe is a residential home which provides accommodation and personal care for up to 28 older people. At the time of the inspection there were 18 people living at the service.

Bedrooms at the home are located over two floors and a lift is available. There is a lounge, conservatory and dining room on the ground floor and all rooms have wheelchair access. All rooms are single occupancy. There are suitably equipped toilet and bathroom facilities on each floor.

At the time of our inspection there was a registered manager in post who had been registered with the Commission since January 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 9 July 2015, we asked the provider to make improvements to staffing levels at the home and the management of complaints. The provider sent us an action plan detailing the improvements that had been made. During this inspection we found that further improvements were required in relation to staffing levels at the home. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe at the home. However, some people living at the home and some relatives expressed concerns about staffing levels at the service. Some of the staff we spoke with felt that staffing levels at the home were not sufficient to meet people's needs. Staffing rotas provided for inspection purposes by the registered manager were not a true reflection of the staff on duty at the home.

We saw evidence that staff had been recruited safely. The staff we spoke with understood how to safeguard vulnerable adults from abuse and what action to take if they suspected abuse was taking place.

There were appropriate policies and procedures in place for managing medicines. However, staff did not always observe that people had taken their medicines and people did not always receive pain medication when they needed it.

We received mixed feedback from people about their satisfaction with the care they received. Some people were happy with the care provided at the home. However, some people felt that their needs were not being met at the home.

People and their relatives expressed concerns about the high staff turnover at the home and felt that this meant that staff did not always know them and how to meet their needs.

We found that staff received an appropriate induction and effective training when they joined the service. Staff told us they received regular supervision.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The service had taken appropriate action where people lacked the capacity to make decisions about their care.

Relatives told us they were involved in decisions about their family member's care and had been involved in their care plan. However, the people we spoke with who lived at the home told us their care plan had not been discussed with them.

People living at the home and relatives were happy with quality of the food provided. However, they told us they would like more variety.

Two of the community healthcare professionals who provided feedback about the service, told us that people's care needs were not always met and appropriate levels of hygiene were not always maintained at the home.

We observed staff communicating with people in a kind and caring way.

People told us staff respected people's privacy and dignity and encouraged them to be independent.

Activities were provided by care staff at the home. However, some people felt that there was a lack of variety regarding what was available.

We saw evidence that the registered manager requested feedback about the service from relatives and acted on the feedback received.

Most people and relatives we spoke with were happy with the management of the service. However, one relative felt the service was not managed well and two staff told us the registered manager was unsupportive and unapproachable.

A variety of audits were completed regularly by the registered manager. However, we did not see evidence that the service provider completed checks to ensure that appropriate levels of care and safety at the home were maintained.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The registered manager followed safe recruitment practices when employing new staff.

People felt safe at the home. However, some people living at the home, their relatives and staff expressed concerns about staffing levels. We found evidence that staffing levels at the service were not always sufficient to meet people's needs.

There were some safe medicines management processes in place. However, staff did not always observe that people had taken their medicines and people did not always receive pain relief medication when they needed it.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff told us they received an appropriate induction and effective training when they joined the service. We saw evidence that staff training was updated regularly.

People's mental capacity was assessed when appropriate and relatives were involved in best interests decisions. DoLS applications had been submitted to the local authority when appropriate.

Some people living at the home felt that staff did not always know how to meet their needs.

Some health professionals involved with the service told us people's basic care needs were not always met.

Requires Improvement ●

Is the service caring?

The service was not always caring.

We observed staff interacting with people in a friendly and caring way.

Requires Improvement ●

People living at the home and their relatives told us staff respected people's privacy and dignity and encouraged them to be independent.

People living at the home felt they were not always supported by staff who knew them.

Is the service responsive?

The service was not always responsive.

People and their relatives expressed concerns about the high staff turnover at the home. They felt that staff did not always know people living at the home and how to meet their needs.

People were supported by staff to take part in social activities within the home.

We found evidence that the registered manager sought feedback from people living at the home and their relatives and used the feedback received to develop the service.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Most staff felt well supported by the registered manager. However, two staff told us that they felt the registered manager was unsupportive and unapproachable.

The registered manager regularly audited different aspects of the service. However, there was no evidence that the service provider completed checks to ensure that appropriate levels of care and safety at the home were maintained.

The registered manager had not submitted notifications to the Commission regarding safeguarding issues in line with current regulations.

Requires Improvement ●

Clitheroe

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5 and 6 July 2016 and the first day was unannounced. We carried out a further visit on 13 July 2016, following the receipt of concerns about care provided at the service. The inspection was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service including concerns, complaints and statutory notifications received from the service. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed previous inspection reports.

We contacted five community healthcare agencies who were involved with the service for their comments. We also contacted Lancashire County Council contracts team for information.

During the inspection we spoke with six people who lived at the service, four relatives who were visiting, six care staff, one member of domestic staff and the registered manager. We observed staff providing care and support to people over the three days of the inspection and reviewed in detail the care records of three people who lived at the service. We also looked at service records including staff recruitment, supervision and training records, policies and procedures, complaints and compliments records, records of audits completed and fire safety and environmental health records.

Is the service safe?

Our findings

The people we spoke with told us they felt safe at the home. However, one person said, "If anything serious happened, I may have concerns over the number of staff available".

At our last inspection on 9 July 2015, we asked the provider to make improvements to staffing levels at the home. The provider sent us an action plan detailing the improvements they planned to make. During this inspection we found that further improvements were needed.

Prior to our inspection we had received a number of concerns about staffing levels at the home. The registered manager informed us that staffing levels at the home were based upon the needs and level of dependency of the people living at the home. She did not use a recognised tool to support her decision making around staff levels.

The registered manager told us that the minimum staffing level for the home at that time was three care staff between 8am and 8pm and two care staff between 8pm and 8am. An additional member of staff was on duty from 8pm to 10pm to support people with their night routine, as this had been identified as a busy time. The registered manager provided us with a copy of the staffing rota for the four week period covering the dates of our inspection. We noted that on all except one date, staffing levels met or exceeded those described to us by the registered manager.

Following our initial inspection on 5 and 6 July 2016, we received information that the staff rotas we had been given during the inspection were not a true reflection of staffing levels at the service. We visited the home again on 13 July 2016 and the registered manager provided the accurate version, which showed that there were at least 12 dates when the minimum staffing levels had not been met. When we discussed this with the registered manager she denied that she had given us the alternative rota to present a false picture of staffing levels at the home.

Five people living at the home and two relatives expressed concerns about staffing levels at the home. They told us they felt poor staffing levels were compromising care. Two of the staff we spoke with also expressed concerns about staffing levels at the service.

During the first and third day of our inspection we noted that staff were busy and there were sometimes delays in responding to call bells. On the second day of our inspection, when there was one more staff on duty than the usual staffing level for the home, staff were able to respond to people more quickly and the atmosphere in the home was more relaxed. We discussed our concerns about staffing levels with the registered manager who advised that she felt the usual staffing levels at the home were sufficient to meet people's needs.

Prior to our inspection, we had received a number of concerns that the service was short staffed and three of the staff we spoke with also raised these concerns. The staffing rota we reviewed showed that on some occasions staff had worked six or seven days in a row without a day off.

Following our inspection we received further concerns about staffing levels at the home.

The provider did not have sufficient staff on duty to meet the needs of people living at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff training and found that all staff had received training in safeguarding vulnerable adults from abuse, in the previous 12 months. The staff we spoke with confirmed they had completed safeguarding training. They understood how to recognise abuse and were clear about what action to take if they suspected abuse was taking place. However, two staff were not aware that they could report safeguarding concerns direct to the local authority. There was a safeguarding vulnerable adults policy in place which identified the different types of abuse, signs of abuse and staff responsibilities. The contact details for the local authority were included.

We looked at how risks were managed in relation to people living at the service. We found the provider had detailed risk assessments in place which included those relating to falls, moving and handling, skin integrity and nutrition. Each assessment included information for staff about the nature of the risk and how it should be managed. Risk assessments were completed by the registered manager and were reviewed monthly or sooner if there was a change in the level of risk.

Records were kept in relation to accidents that had taken place at the service, including falls. The records were detailed and were signed and dated by staff. Information included the action taken by staff at the time of the accident and any injuries sustained. We saw evidence that accidents and incidents were reviewed by the registered manager.

Records showed that all staff had completed up to date moving and handling training. During our inspection we observed staff adopting safe moving and handling practices when supporting people to move around the home.

We looked at the recruitment records for three members of staff and found the necessary checks had been completed before staff began working at the service. This included an enhanced Disclosure and Barring Service (DBS) check, which is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. A full employment history, proof of identification and a minimum of two written references had been obtained. These checks would help to ensure that the service provider made safe recruitment decisions.

We looked at whether people's medicines were managed safely. We observed staff administering medicines and saw that people were given time to take their medicines without being rushed. Staff explained what they were doing and sought people's consent. Medicines were stored securely in a locked trolley and there were appropriate processes in place to ensure medicines were ordered, administered and disposed of safely. The service used a blister pack system for most medicines. This is where the medicines for different times of the day are received from the pharmacy in dated and colour coded packs, which helps to avoid error.

We found that MAR sheets provided clear information for staff, including pictures and descriptions of medicines. A picture of the person, their date of birth and any allergies were also recorded. Medicines were clearly labelled and staff had signed the MAR sheets to demonstrate that medication had been administered.

A medicines policy was available which included safe storage and disposal, record keeping, consent, refusal

of medicines and staff training and assessment. Information was also available for staff in respect of over the counter remedies and provided clear guidance for staff, which included the need for GP authorisation.

We noted that all staff had received basic medicines training and the senior staff who administered medicines had completed additional 'Medicines Handling' training. We saw evidence that staff members' competence to administer medicines safely was assessed yearly. Records showed that medicines audits were completed monthly. An action plan was created where improvements were needed.

Four people we spoke with told us they received their medicines when they should and pain relief when they needed it. However, one person told us, "Sometimes I'm in pain and I have to wait a long time for staff to come when they're busy". Another person told us that on some occasions their medicines had been left on the table resulting in their evening medicines being missed. Three relatives told us they were happy with how people's medicines were managed at the home. However, one relative told us staff didn't usually observe their family member taking their medicine, they just left it on their table.

We contacted a local pharmacist about the service. He told us, "Generally the home is very good around medication". The pharmacist did not have any concerns about the home.

We looked at the arrangements for keeping the service clean. Prior to our inspection we had received concerns about levels of hygiene at the home. We noted that the home did not have a dedicated cleaner. Care staff and one of the cooks worked shifts as cleaners at the home. During both days of our inspection we observed cleaning being carried out. We noticed an odour on the middle floor of the home during the first morning of our inspection. We discussed this with the registered manager and found later that the odour was no longer present. We found the standard of hygiene in the home during our inspection to be satisfactory and this was confirmed by the people we spoke with and their relatives. However, one community professional we contacted for feedback about the service told us that people's continence needs were not always managed appropriately and appropriate standards of hygiene at the home were not always maintained.

Infection control policies and procedures were available, which included guidance regarding personal protective equipment, hand washing, outbreak control measures and clinical waste. Records showed that all staff had completed up to date infection control training.

Environmental risk assessments were in place and were reviewed regularly. This included checks for Legionella bacteria which can cause Legionnaires Disease, a severe form of pneumonia. These checks would help to ensure that the people living at the service were living in a safe environment. All staff had completed health and safety training and first aid training in the previous 12 months.

We noted that all staff had completed food hygiene training and in January 2015 the Food Standards Agency had awarded the service a food hygiene rating of 5 (very good). This meant that processes were in place to ensure that people's meals were prepared safely.

Records showed that all staff had completed fire safety training in the previous 12 months. There was evidence that the fire alarm, fire extinguishers and emergency lighting, which would activate if the normal service failed, were tested regularly. A fire drill took place weekly. We noted that a fire safety audit had been completed by Lancashire Fire and Rescue service in October 2014 and the necessary minor compliance actions had been completed. We saw evidence that the registered manager completed a yearly fire risk assessment and regular checks of escape routes and the fire alarm. These checks would help to ensure that people living at the service were kept safe in an emergency. An emergency evacuation plan was in place for each person living at the home.

Records showed that equipment at the service, including hoists and the lift, was safe and had been serviced and portable appliances were tested yearly. Gas and electrical appliances were also tested regularly. This would help to ensure that people received care in a safe environment.

Is the service effective?

Our findings

People gave us mixed feedback about the care being provided at Clitheroe. Two people we spoke with felt that staff had the skills to meet their needs. However, two people felt that there was a variation in skills in the staff team, which led to some variation from shift to shift. One relative we spoke with also felt that staff skills at the home varied and that this impacted on the care people received. They told us that on one occasion a member of staff had asked residents where the bed pans were kept.

Three people we spoke with expressed concerns about the high turnover of staff at the home and felt that this impacted on how well staff knew people and how to meet their needs. One relative felt that the high turnover of staff at the home resulted in a lack of stability in the home and, "A lack of real knowledge of the residents' needs". One community professional we contacted raised concerns about the high staff turnover at the home and told us they felt this impacted on the continuity of care provided to people.

Records showed that all staff had completed an induction programme which included safeguarding vulnerable adults, moving and handling, infection control and fire safety. The staff we spoke with told us they had received an effective induction and had been given the opportunity to observe experienced staff and become familiar with people's needs before becoming responsible for providing their care. This helped to ensure that staff provided safe care and were able to meet people's needs.

There was a training plan in place which identified training that had been completed by staff and detailed when further training was scheduled or due. In addition to the training mentioned previously, all staff had completed Managing Challenging Behaviour training and 50% in dementia care. Almost all staff were trained to NVQ (National Vocational Qualification) level 2. The registered manager showed us a handbook that was given to all staff when they started working at the service. We noted that the handbook included information about health and safety and whistle blowing. This would help to ensure that staff knew how to provide safe care and how to report poor practice.

Staff told us that a verbal and written handover took place between staff prior to each shift change. We reviewed handover records and noted they included information about people's personal care, mood, meals, any visits from relatives or professionals and any accidents or injuries. Any concerns were clearly recorded. This would help to ensure that staff were aware of any changes in people's risks or needs.

We looked at how the service addressed people's mental capacity. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found that people's mental capacity had been assessed and appropriate applications had been submitted to the local authority when it was felt that people needed to be deprived of their liberty to ensure their safety. At the time of our inspection, the registered manager had submitted applications to the local authority in respect of four people living at the home. No authorisations had been received. We saw evidence that where people lacked the capacity to make decisions about their care, their relatives had been consulted and decisions had been made in their best interests.

MCA and DoLS policies, procedures and guidance were in place. All staff had completed DoLS and MCA training in the previous 12 months. The staff we spoke with understood the main principles of the legislation, including the importance of gaining people's consent when providing support and ensuring people were encouraged to make decisions about their care when they could. During our inspection we observed staff supporting people sensitively who displayed some level of anxiety or confusion.

During our visit we observed staff routinely asking people for their consent when providing care and treatment, for example when administering medicines or supporting people with meals or with moving from one place to another. We noted that care plans were detailed and documented people's needs and how they should be met, as well as their likes and dislikes.

We noted that DNACPR (do not attempt cardiopulmonary resuscitation) decisions were recorded in people's care files and recorded whether decisions were indefinite or whether they needed to be reviewed. Where a DNACPR decision was in place, staff could identify this quickly and easily as it was in the front of the person's care file. This would help to ensure that any medical treatment was provided in line with the decision.

We looked at how people living at the service were supported with eating and drinking. Everyone we spoke with who lived at the home was happy with the quality of the food and the support provided by the staff. However, people living at the home and their relatives felt there was a lack of variety. One relative told us, "The home has one amazing chef".

We reviewed the home's menus and noted that there were two meal choices at lunch time and in the evening. We spoke with one of the cooks who told us that staff asked people every day what they wanted for each meal and if they did not want what was planned they could have something different. We observed staff doing this on both days of our inspection. The cook told us that staff ensured people always had something they liked. This was confirmed by the people we spoke with, who told us there was lots of choice at mealtimes.

We observed lunch on both days of our inspection. We saw that dining tables were set with table cloths, napkins and condiments and the meals looked appetising and hot. The portions served were ample. On the first day of our inspection, we noted that some people were seated at the dining table 30 minutes before lunch was served. Some people fell asleep while they were waiting. Staff interaction with people during the meal was still generally task driven, with little social interaction with people during the meal.

Care records included information about people's dietary preferences, and risk assessments and action plans were in place where there were concerns about a person's nutrition or hydration. Daily records and handover information included details of how much people had eaten during the day. People's weight was recorded monthly and records showed that appropriate professional advice and support, such as referral to a dietician, was sought when there were concerns about people's weight loss or nutrition.

We looked at how people were supported with their health needs. People living at the service and their relatives felt their health needs were met and told us they could see a doctor or nurse quickly if they needed

to. We found that care plans and risk assessments included detailed information about people's health needs. We saw evidence of referrals to a variety of health care agencies including GPs, podiatrists and district nurses. Healthcare appointments and visits were documented in people's care files. This would help to ensure that people were supported appropriately with their health. We noted a poster on the noticeboard in the entrance of the home advertising that a local optician was visiting the home on 13 July 2016 to complete eye examinations.

We received feedback about the home from five community healthcare agencies. Three agencies did not have any concerns about the home. However, two agencies had concerns about some aspects of care at the home. They told us that there had been delays in obtaining people's prescriptions and that people's basic care needs were not always attended to.

Is the service caring?

Our findings

Everyone we spoke with who lived at the home told us the staff were caring. One person said, "It's the first care home I've seen where a care worker gave a resident a hug". The relatives we spoke with also felt that staff at the home were caring.

During the inspection we observed staff supporting people at various times and in various places throughout the home. We saw that staff communicated with people in a kind and caring way and were patient and respectful.

Most people living at the home told us that staff came when they needed them. However, one person told us they sometimes had to wait for pain relief medication when staff were busy.

We saw evidence that people's care had been discussed with them. Where people did not have the capacity to discuss their care needs, we found evidence that their relatives had been consulted.

We asked five residents if they felt staff knew them and their likes and dislikes. Three people felt that due to the high turnover of staff at the home, staff did not always know them. One person told us, "Some do, some just do not bother and just do their duty."

People told us they could make everyday choices about their care, including what time they got up in the morning and went to bed at night. They told us they could choose what they wore every day and what they ate at mealtimes.

Three people living at the home told us they were encouraged to be independent. However, one person felt that independence was not promoted at the home. Three relatives we spoke with felt that staff at the home encouraged people to be independent. During our inspection we observed staff supporting people appropriately who needed help to move around the home.

All of the relatives we spoke with and three people living at the home told us staff respected people's dignity and privacy. One person told us, "The care workers are very good and thoughtful when providing personal care". We observed that staff knocked on bedroom doors before entering and explained what they were doing when they were providing care or support, such as administering medicines or helping people to move around the home. We noted that people could lock their bedroom doors from the inside and the registered manager told us that they could have a key to their room if they wanted one. Staff had access to a master key if they needed to gain access to the room in an emergency.

There was a noticeboard in the entrance area of the home which displayed a variety of information for people living there and their visitors. Information included the report from the Commission's last inspection of the service, a summary of the residents' survey completed in June 2016, the complaints policy, leaflets about DoLS, dementia and a local carer support service. A poster advertising a local advocacy service was also displayed in the entrance area. Advocacy services can be used if people want support and advice from

someone other than staff, friends or family members. The registered manager told us that at the time of our inspection, none of the people living at the home were using an advocacy service.

Is the service responsive?

Our findings

We received mixed information from people about whether their needs were being met at the home. Two people felt that they received care that reflected their needs. However, three people felt that the high staff turnover at the home meant that staff were not always familiar with their needs and how to meet them.

At our last inspection on 9 July 2015, we asked the provider to make improvements to how complaints about the service were managed. During this inspection we found that further improvements were needed. A complaints, suggestions and compliments policy was available and included timescales for investigation and providing a response. The policy advised that minor complaints should be recorded as well as 'serious or substantial' complaints. Contact details for the Commission and the Local Government Ombudsman were included. Details of the policy were also displayed on the notice board in the entrance area of the home.

We reviewed the record of complaints received and noted that three formal written complaints had been recorded in the previous 12 months. We found that there was a record of the actions taken by the registered manager in response to each complaint and that all had been dealt with within the timescales of the policy.

People living at the home told us they felt able to raise any concerns. One relative told us they had a good relationship with the management team and would raise any concerns with them. However, two relatives told us they had raised concerns with the registered manager previously and no action had been taken. The registered manager showed us a collection of compliments received about the care provided at the service.

We saw evidence that people's needs had been assessed prior to them coming to live at the service, to ensure that the home could meet their needs. The care plans we reviewed had been signed by people living at the home and where people lacked the capacity to make decisions about their care, their relatives had been consulted. The relatives we spoke with told us they had been involved in their family member's care plan. However, four people we spoke with who lived at the home told us they had not been involved in their care plan or discussions about their care.

Care plans and risk assessments were completed by the registered manager and were reviewed monthly by the registered manager or by senior care staff. The care plans and risk assessments we reviewed were individual to the person and explained people's likes and dislikes as well as their needs and how they should be met. Information about people's interests and hobbies was included.

During the first day of our inspection we observed that staff were very busy and there were sometimes delays in answering call bells. The registered manager advised that a member of staff was on sick leave that day, which meant that the registered manager was delivering care. We also noted that there were two GP visits that day. This resulted in less staff being available to support people, as they were assisting the GPs during their visits. On the second day of the inspection, the atmosphere in the home was more relaxed. There were more staff on duty and people's needs were met in a timelier manner. During our inspection, people seemed comfortable and relaxed in the home environment. They could move around the home

freely and could choose where they sat in the lounge and at mealtimes.

Following our initial inspection visits we received concerns that night staff were being asked to get people up from 5am, as there were not enough staff on duty in the day to support people with getting washed and dressed in the morning. We visited the home again at 7am on 13 July 2016 to address these concerns. We found that a number of people were already up and dressed. We spoke people and staff and reviewed people's care documentation. We did not find any evidence that staff had got people out of bed without their consent or against their wishes.

During our inspection we observed staff communicating with people living at the home. People were given the time they needed to make decisions and answer questions. Staff spoke clearly and repeated information when necessary.

A weekly calendar of activities was on display in the entrance area, which listed an activity each morning and afternoon. Activities available included quizzes, armchair games, pamper sessions, board games, arts and crafts and bingo. The home did not have a dedicated activities co-ordinator; the care staff on duty were responsible for arranging and facilitating the activities each day.

During our inspection activities were available each morning and afternoon. These included snakes and ladders, skittles and armchair balloon games. The people we spoke with confirmed that some activities took place at the home. However, they felt that these tended to focus on quizzes and bingo. One person told us they felt the activities were, "Too childish". Relatives also confirmed that some activities took place at the home. One relative told us that the programme of activities was a little light and lacked substance. They said it was not clear who was responsible for organising them. A hairdresser attended the home during our inspection and we were told that she visited weekly. We were told that anyone who wanted their hair cut or styled could see her.

We recommend that the service seek advice and guidance from a reputable source, about the provision of meaningful activities for people living at the home.

We looked at how the service sought feedback from the people living there and their relatives. The registered manager told us that satisfaction questionnaires were given to people and their relatives yearly to gain their views about the care being provided. We reviewed the questionnaires issued in June 2016 and noted that questionnaires had been given to nine people living at the service. Eight people had responded. People provided positive feedback about many aspects of the home. However, we noted that a low level of satisfaction was expressed about issues including cleaning, laundry and food. Questionnaires had also been issued to 10 relatives and eight had been returned. Positive feedback was provided about a variety of issues at the home, including how people were treated by care staff and how people's privacy and dignity was respected. However, some dissatisfaction was expressed about laundry, cleaning and activities at the home. We saw some evidence during our inspection that the feedback received had been used to make improvements, such as menus being changed and new processes being introduced for the management of laundry. The relatives we spoke with confirmed they had received satisfaction questionnaires from the home.

Records showed that residents meetings took place monthly. We reviewed the notes of the meetings in 2015 and 2016 and saw that issues addressed discussed included the home's menus, laundry, activities, trips and any suggestions for improvement. We noted that the menus at the home had been reviewed, following discussions about this at residents' meetings. The residents we spoke with during our inspection told us they were not aware of resident meetings having taken place at the home and told us they had not been

asked to provide feedback about the care they received.

The registered manager told us that the home previously provided regular residents newsletters and this was something she planned to reintroduce.

Is the service well-led?

Our findings

We received mixed feedback about the management of the home. Four of the relatives we spoke with felt the home was well managed and the registered manager was approachable. One relative told us, "The home is run well with friendly staff". However one relative felt that the home lacked good management and the registered manager "Made commitments that did not happen in practice".

Records showed staff meetings took place at least twice a year. The meetings were used to address issues relating to the care provided at the home, staff training, any changes in residents needs and any health and safety issues. The staff we spoke with confirmed that staff meetings took place.

The registered manager provided us with a summary of the staff questionnaires issued in June 2016. We noted that 11 questionnaires had been issued and 10 had been returned. A high level of satisfaction had been expressed about all issues including induction, training and the approachability of management.

We saw evidence that staff received regular supervision and the staff members we spoke with confirmed this. Of the six care staff we spoke with, four staff told us they felt the registered manager was supportive. However, two staff told us they felt the registered manager was unapproachable, unsupportive and they did not feel able to raise concerns with her. One member of staff who had told us the manager was supportive, contacted us after the inspection. They told us that the manager was unsupportive and that all staff had been told by the registered manager what to say to the inspector during our inspection.

We received concerns from staff prior to, during and after our inspection about staffing levels at the home and the registered manager putting pressure on staff to cover shifts when other staff were on annual leave or off work due to illness. During our initial inspection visits, the registered manager provided us with a staff rota that did not reflect staffing levels at the home. When we received an accurate rota, we found that there were numerous occasions when the minimum staffing levels described by the registered manager had not been met and on some occasions staff had worked six or more days in a row without a break. However, when we discussed these issues with the registered manager she told us that the service was not short staffed and felt that the staffing levels at the home were adequate to meet people's need. Our inspection found that there were instances where additional staff were required to be available at the home.

A whistleblowing (reporting poor practice) policy was in place. The staff we spoke with were aware of the policy and told us they would feel able to use it if they were concerned about the poor practice of a colleague.

We noted that the registered manager audited different aspects of the service regularly. In addition to the medicines mentioned previously, we saw evidence that infection control, equipment, care documentation and the home environment were audited regularly.

We saw evidence that the service provider met with the registered manager regularly to discuss the running of the home and any concerns. However, we did not see evidence that the provider reviewed standards of

care at the home or the registered manager's practice. This meant that the provider could not be sure that appropriate standards of care and safety were being achieved and maintained at the home.

We noted that the provider's mission statement was, 'To provide a secure, stable and comfortable environment, whilst providing a standard of individual mental and physical care, which ensures that each service user is as happy and contented as possible'. We saw evidence during our inspection that this level of care was not always achieved at the home. The registered manager informed us she felt well supported by the service provider and advised that resources were made available to her to achieve what she felt were appropriate standards of care and safety at the home.

Our records showed that the service had submitted some statutory notifications to the Commission about people living at the service. However, we noted that the registered manager had not sent the Commission notifications regarding safeguarding incidents, in line with the current regulations. We discussed this with the registered manager who advised that she was not aware she needed to do this. She assured us that she would send us all relevant notifications in the future.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. We have written to the service provider separately about this issue.

There was a business continuity plan in place which provided guidance to staff in the event of the loss of amenities such as gas, electricity, water or heating. This helped to ensure that people received appropriate care if the service was disrupted.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff on duty to meet the needs of people living at the home.

The enforcement action we took:

We sent the provider a warning notice and have asked them to achieve compliance by 10 October 2016.